FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040741

Facility Name: DEERBROOK CARE CENTRE

Address: 306 NORTH LARKIN AVENUE (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

Telephone Number: (815) 744-5560 **Fax #** (815) 744-6914

IDPA ID Number: 36-3943427001

Date of Initial License for Current Owners: 04/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHAEL BELLOWS

(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	214	Skilled (SNF)	214	78,110	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	214	TOTALS	214	78,110	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,425	1,029	10,625	18,079	8
9	SNF/PED					9
10	ICF	36,211	5,799	1,857	43,867	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,636	6,828	12,482	61,946	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.31%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 214 and days of care provided 6,436

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	282,059	24,739	14,990	321,788		321,788	(3,152)	318,636			1
2	Food Purchase		213,251		213,251		213,251	(1,366)	211,885			2
3	Housekeeping	154,741	39,468		194,209		194,209	1,574	195,783			3
4	Laundry	75,817	23,129		98,946		98,946	(915)	98,031			4
5	Heat and Other Utilities			166,877	166,877		166,877		166,877			5
6	Maintenance	93,069	32,920	33,218	159,207		159,207	(2,678)	156,529			6
7	Other (specify):*			14,357	14,357		14,357		14,357			7
8	**TOTAL General Services**	605,686	333,507	229,442	1,168,635		1,168,635	(6,537)	1,162,098			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	2,695,317	215,064	134,735	3,045,116		3,045,116	(47,609)	2,997,507			10
10a	Therapy											10a
11	Activities	187,686	6,647		194,333		194,333	(55)	194,278			11
12	Social Services	37,908			37,908		37,908		37,908			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,920,911	221,711	144,335	3,286,957		3,286,957	(47,664)	3,239,293			16
	C. General Administration											
17	Administrative	204,145		781,931	986,076		986,076	(799,426)	186,650			17
18	Directors Fees											18
19	Professional Services			402,784	402,784		402,784	(277,803)	124,981			19
20	Dues, Fees, Subscriptions & Promotions			210,983	210,983		210,983	(181,578)	29,405			20
21	Clerical & General Office Expenses	349,398	40,046	56,152	445,596		445,596	190,063	635,659			21
22	Employee Benefits & Payroll Taxes			734,104	734,104		734,104		734,104			22
23	Inservice Training & Education			6,462	6,462		6,462		6,462			23
24	Travel and Seminar			288	288		288	10,954	11,242			24
25	Other Admin. Staff Transportation			4,142	4,142		4,142		4,142			25
26	Insurance-Prop.Liab.Malpractice			246,046	246,046		246,046	31,476	277,522			26
27	Other (specify):*			102,500	102,500		102,500	(102,500)				27
28	**TOTAL General Administration**	553,543	40,046	2,545,392	3,138,981		3,138,981	(1,128,814)	2,010,167			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,080,140	595,264	2,919,169	7,594,573		7,594,573	(1,183,015)	6,411,558			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: DEERBROOK CARE CENTRE **#0040741** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	13,054	
	REPAIRS & MAINTENANCE		1,936	
			0	14,990
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		40,556	
	ELECTRICITY		83,245	
	WATER		43,076	
	CABLE TV - LOBBY		0	
			0	166,877
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,870	
	PAINTING & DECORATING		3,753	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		9,444	
	ELEVATOR MAINTENANCE & REPAIR		8,802	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,050	
	FIRE SERVICE		3,299	
			0	
			0	
			0	33,218
7	**OTHER**			
	SCAVENGER		14,259	
	SECURITY SERVICE		98	14,357
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,600	9,600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	3,850	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	125,206	
	PSYCHOLOGIST	XVIII B 47-2	5,679	
			0	134,735
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DEERBROOK CARE CENTRE #0040741 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	781,931	781,931
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	42,652	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	360,132	
			0	402,784
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	120,241	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	49,805	
	EMPLOYEE WANT ADS	XIX F	12,365	
	CONTRIBUTIONS	VI 20 XIX F	470	
	DUES & SUBSCRIPTIONS	XIX F	11,375	
	LICENSES & PERMITS	XIX F	3,313	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	7,327	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,335	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	752	210,983
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		514	
	EQUIPMENT REPAIR & MAINTENANCE		5,375	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,498	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		45,413	
	MESSENGER SERVICE		1,352	
			0	56,152

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	306,709	
	UNEMPLOYMENT COMPENSATION	XIX D	55,894	
	WORKERS COMPENSATION INSURANCI	XIX D	110,700	
	HOSPITALIZATION INSURANCE	XIX D	235,568	
	EMPLOYEE BENEFITS - OTHER	XIX D	12,234	
	EMPLOYEE PHYSICAL EXAMS	XIX D	3,510	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	9,489	
	CHICAGO HEAD TAX	XIX D	0	734,104
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		6,462	6,462
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	288	
			0	
			0	288
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,142	4,142
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		246,046	246,046
27	**OTHER**			
	BAD DEBTS	VI 24	102,500	
				102,500

GRAND TOTAL COLUMN 3 OTHER 2,919,169

DEERBROOK CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	213,251	PATIENT MEALS	185838
LESS SALES TAX	(1,366)	ADD EMPLOYEE MEALS	0
NET FOOD	211,885	TOTAL MEALS/YEAR	185838
TOTAL PATIENT CENSUS	61,946	NET FOOD	211885
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	185838
TOTAL PATIENT MEALS	185838	COST PER MEAL	1.14
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number DEERBROOK CARE CENTRE #0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,589	54,589		54,589	238,173	292,762			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,671	4,671		4,671	278,833	283,504			32
33	Real Estate Taxes			94,440	94,440		94,440		94,440			33
34	Rent-Facility & Grounds			792,050	792,050		792,050	(751,893)	40,157			34
35	Rent-Equipment & Vehicles			36,097	36,097		36,097	10,104	46,201			35
36	Other (specify):* STORAGE			2,449	2,449		2,449		2,449			36
37	TOTAL Ownership			984,296	984,296		984,296	(224,783)	759,513			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		284,655	697,200	981,855		981,855		981,855			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,165	117,165		117,165		117,165			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		284,655	814,365	1,099,020		1,099,020		1,099,020			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,080,140	879,919	4,717,830	9,677,889		9,677,889	(1,407,798)	8,270,091			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,116	30		9
10	Interest and Other Investment Income	(4,671)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,366)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(3,498)	21		18
19	Entertainment	(120,241)	20		19
20	Contributions	(5,805)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(721)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(102,500)	27		24
25	Fund Raising, Advertising and Promotional	(49,805)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,327)	20		28
29	Other-Attach Schedule	(20,514)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (300,332)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,107,466)	PG 6-6E	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,107,466)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,407,798)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

DEERBROOK CARE CENTRE

ID# 0040741

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (2,539)	6	1
2	VACATION ACCRUAL	(3,152)	1	2
3	VACATION ACCRUAL	1,574	3	3
4	VACATION ACCRUAL	(915)	4	4
5	VACATION ACCRUAL	(139)	6	5
6	VACATION ACCRUAL	12,106	10	6
7	VACATION ACCRUAL	(55)	11	7
8	VACATION ACCRUAL	(19,079)	17	8
9	VACATION ACCRUAL	(8,315)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(20,514)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(3,152)	0	0	0	0	0	0	0	0	0	0	(3,152)	1
2	Food Purchase	(1,366)	0	0	0	0	0	0	0	0	0	0	(1,366)	2
3	Housekeeping	1,574	0	0	0	0	0	0	0	0	0	0	1,574	3
4	Laundry	(915)	0	0	0	0	0	0	0	0	0	0	(915)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,678)	0	0	0	0	0	0	0	0	0	0	(2,678)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,537)	0	0	0	0	0	0	0	0	0	0	(6,537)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	12,106	0	0	(59,715)	0	0	0	0	0	0	0	(47,609)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(55)	0	0	0	0	0	0	0	0	0	0	(55)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	12,051	0	0	(59,715)	0	0	0	0	0	0	0	(47,664)	16
	C. General Administration													
17	Administrative	(19,079)	0	(584,864)	0	0	(195,483)	0	0	0	0	0	(799,426)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(721)	8,004	(88,523)	1,492	(198,055)	0	0	0	0	0	0	(277,803)	19
20	Fees, Subscriptions & Promotions	(183,178)	0	888	298	414	0	0	0	0	0	0	(181,578)	20
21	Clerical & General Office Expenses	(11,813)	0	31,168	2,213	168,495	0	0	0	0	0	0	190,063	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,092	5,145	2,717	0	0	0	0	0	0	10,954	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	25,530	1,754	2,094	2,098	0	0	0	0	0	0	31,476	26
27	Other (specify):*	(102,500)	0	0	0	0	0	0	0	0	0	0	(102,500)	27
28	**TOTAL General Administration**	(317,291)	33,534	(636,485)	11,242	(24,331)	(195,483)	0	0	0	0	0	(1,128,814)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(311,777)	33,534	(636,485)	(48,473)	(24,331)	(195,483)	0	0	0	0	0	(1,183,015)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	16,116	222,057	0	0	0	0	0	0	0	0	0	238,173	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,671)	283,504	0	0	0	0	0	0	0	0	0	278,833	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(792,050)	0	1,244	38,913	0	0	0	0	0	0	(751,893)	34
35	Rent-Equipment & Vehicles	0	0	3,211	4,560	2,333	0	0	0	0	0	0	10,104	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	11,445	(286,489)	3,211	5,804	41,246	0	0	0	0	0	0	(224,783)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(300,332)	(252,955)	(633,274)	(42,669)	16,915	(195,483)	0	0	0	0	0	(1,407,798)	45

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		DEERBROOK NURSING CENTRE		
OWNERS		NURSING HOMES			MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED		
				ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 792,050	DEERBROOK NURSING CENTRE		$	$ (792,050)	1
2	V	19	ACCOUNTING		" "		7,800	7,800	2
3	V	26	MORTGAGE INSURANCE		" "		25,530	25,530	3
4	V	30	DEPRECIATION-BLDG IMP		" "		221,599	221,599	4
5	V	30	DEPRECIATION - EQPT & FN		" "		458	458	5
6	V	32	AMORTIZATION - MTG COST		" "		1,256	1,256	6
7	V	32	MORTGAGE INTEREST		" "		254,242	254,242	7
8	V	32	INTEREST - OTHER		" "		28,006	28,006	8
9	V	19	DATA PROCESSING		" "		204	204	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 792,050			$ 539,095	$ * (252,955)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 102,544	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		$ 14,021	$ (88,523)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		888	888	16
17	V	21	CLERICAL		" "		31,168	31,168	17
18	V	24	TRAVEL		" "		3,092	3,092	18
19	V	26	INSURANCE		" "		1,754	1,754	19
20	V	35	RENT - EQPT & VEH		" "		3,211	3,211	20
21	V	17	ADMINISTRATIVE	586,448	" "		1,584	(584,864)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 688,992			$ 55,718	$ * (633,274)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 123,431	CARLYLE NURSING ASSOCIATES, LLC		$ 63,716	$ (59,715)	15
16	V	19	PROFESSIONAL FEES		" "		1,492	1,492	16
17	V	20	DUES & SUBSCRIPTIONS		" "		298	298	17
18	V	21	CLERICAL		" "		2,213	2,213	18
19	V	24	TRAVEL		" "		5,145	5,145	19
20	V	26	INSURANCE		" "		2,094	2,094	20
21	V	30	DEPRECIATION		" "				21
22	V	34	RENT		" "		1,244	1,244	22
23	V	35	RENT - EQPT & VEH		" "		4,560	4,560	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 123,431			$ 80,762	$ * (42,669)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 203,058	THE KENSINGTON GROUP, LLC		$ 5,003	$ (198,055)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		414	414	16
17	V	21	CLERICAL		" "		168,495	168,495	17
18	V	24	TRAVEL		" "		2,717	2,717	18
19	V	26	INSURANCE		" "		2,098	2,098	19
20	V	30	DEPRECIATION		" "				20
21	V	34	RENT		" "		38,913	38,913	21
22	V	35	RENT - EQPT & VEH		" "		2,333	2,333	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 203,058			$ 219,973	$ * 16,915	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 195,483	CHESTERFIELD, LLC		$	$ (195,483)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 195,483			$ 0	$ * (195,483)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WITTINGHAM MANAGEMENT ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	328,617	6	$ 74,383	$	61,946	$ 14,021	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	328,617	6	4,713		61,946	888	2
3	21	CLERICAL	PATIENT DAYS	328,617	6	165,350	139,276	61,946	31,168	3
4	24	TRAVEL	PATIENT DAYS	328,617	6	16,404		61,946	3,092	4
5	26	INSURANCE	PATIENT DAYS	328,617	6	9,305		61,946	1,754	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	328,617	6	17,037		61,946	3,211	6
7	17	ADMINISTRATIVE	PATIENT DAYS	328,617	6	8,406	8,406	61,946	1,584	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 295,598	$ 147,682		$ 55,718	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARLYLE NURSING ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	1	$ 63,716	$ 63,716	1	$ 63,716	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	9	11,646		61,946	1,492	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	9	2,323		61,946	298	3
4	21	CLERICAL	PATIENT DAYS	483,650	9	17,276		61,946	2,213	4
5	24	TRAVEL	PATIENT DAYS	483,650	9	40,167		61,946	5,145	5
6	26	INSURANCE	PATIENT DAYS	483,650	9	16,351		61,946	2,094	6
7	30	DEPRECIATION	PATIENT DAYS	483,650	9			61,946		7
8	34	RENT	PATIENT DAYS	483,650	9	9,715		61,946	1,244	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	483,650	9	35,603		61,946	4,560	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 196,797	$ 63,716		$ 80,762	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE KENSINGTON GROUP, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	9	$ 39,055	$	61,946	$ 5,003	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	9	3,234		61,946	414	2
3	21	CLERICAL	PATIENT DAYS	483,650	9	1,315,340	1,150,879	61,946	168,495	3
4	24	TRAVEL	PATIENT DAYS	483,650	9	21,213		61,946	2,717	4
5	26	INSURANCE	PATIENT DAYS	483,650	9	16,374		61,946	2,098	5
6	30	DEPRECIATION	PATIENT DAYS	483,650	9			61,946		6
7	34	RENT	PATIENT DAYS	483,650	9	303,769		61,946	38,913	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	483,650	9	18,215		61,946	2,333	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,717,200	$ 1,150,879		$ 219,973	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - DEERBROOK NURSING CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE	$61,407.35		4,775,900	4,682,978	12/38	5.4000	254,242	2
3	GMAC		X	LOAN COST	AMORT - 35 YEARS		43,959	41,388			1,256	3
4												4
5												5
	Working Capital											
6	LETTER OF CREDIT FEE		X								4,671	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	DEMAND	233,532	310,194	VARIES	VARIES	28,006	7
8												8
9	TOTAL Facility Related				$61,407.35		$ 5,053,391	$ 5,034,560			$ 288,175	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,053,391	$ 5,034,560			$ 288,175	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	89,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	91,416	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,016	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	92,424	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	94,440	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	79,847	8
2001	82,957	9
2002	88,752	10
2003	88,433	11
2004	91,416	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DEERBROOK CARE CENTRE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0040741

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-07-401-034-0000	NURSING HOME	$ 91,416.00	$ 91,416.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 91,416.00	$ 91,416.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,380 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	105,000	1975	$ 247,500	1
2	754 BASIS ADJ		1992	13,220	2
3	TOTALS	105,000		$ 260,720	3

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	214			1975	$ 1,849,704	$ 29,750	35	$ 52,849	$ 23,099	$ 1,597,605	4
5				1980	168,687	1,331	20		(1,331)	168,687	5
6	754 ADJ			1992	125,584	11,622	27.5	4,567	(7,055)	61,461	6
7	754 ADJ.			2001	29,192	1,062	27.5	1,062		5,310	7
8											8
	Improvement Type**										
9	**********RELATED PARTY - DEERBROOK NURSING CENTRE**********										9
10	IMPROVEMENTS			1984	33,823	331	20		(331)	33,823	10
11	IMPROVEMENTS			1986	21,535	366	20	1,077	711	21,001	11
12	IMPROVEMENTS			1987	78,860	2,868	20	3,943	1,075	73,391	12
13	IMPROVEMENTS			1988	48,614	1,768	31.5	1,544	(224)	26,676	13
14	IMPROVEMENTS			1989	60,430	2,197	31.5	1,919	(278)	32,444	14
15	IMPROVEMENTS			1990	30,485	1,108	31.5	967	(141)	14,644	15
16	IMPROVEMENTS			1991	53,134	1,931	31.5	1,688	(243)	24,344	16
17	IMPROVEMENTS			1992	117,363	4,267	31.5	3,725	(542)	49,664	17
18	IMPROVEMENTS			1993	29,335	1,067	39	752	(315)	11,787	18
19	IMPROVEMENTS			1993	29,864	1,085	27.5	1,085		9,778	19
20	IMPROVEMENTS			1994	37,711	1,371	27.5	1,371		15,521	20
21	VINYL SLIDER UNITS			1995	3,070	112	27.5	112		1,171	21
22	DOORS			1995	2,564	93	27.5	93		973	22
23	ROOF			1996	24,069	875	27.5	875		8,349	23
24	OUR TOWN			1996	74,400	2,705	27.5	2,705		24,458	24
25	ROOF/REMODEL KITCHEN/DUMPSTER/FLOORS			1997	448,432	16,005	27.5	16,005		134,453	25
26	ALZHEIMERS WING CONSTRUCTION			1997	1,590,575	57,833	27.5	57,833		481,385	26
27	OUR TOWN			1998	21,500	782	27.5	782		6,223	27
28	ALZHEIMERS WING CONSTRUCTION - FINAL DRAW			1998	17,009	618	27.5	618		4,919	28
29	DINING ROOM FLOOR - TILES			1998	30,000	1,091	27.5	1,091		8,683	29
30	DOOR ALARM SYSTEMS			1998	24,760	900	27.5	900		7,163	30
31	SPRINKLERS			1998	3,500	127	27.5	127		1,011	31
32	DINING ROOM - WALLPAPER/TILE BASE			1998	14,900	542	27.5	542		4,268	32
33	RENOVATE 2 ROOMS/REPLACE ELEVATOR FLOORS			1998	9,400	342	27.5	342		2,665	33
34	REMODELING OF ELEVATOR - LOBBY			1998	7,050	256	27.5	256		1,974	34
35	LANDSCAPING			1998	2,815	102	27.5	102		787	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ROOF TOP PTAC UNITS	1998	$ 3,508	$ 128	27.5	$ 128	$	$ 986	37
38	DINING & RESIDENT ROOM FLOORS	1998	15,268	555	27.5	555		4,232	38
39	HOT WATER TANK	1998	1,780	65	27.5	65		495	39
40	REMODELING - SHOWER ROOM	1998	3,830	139	27.5	139		1,025	40
41	ASPHALT PARKING LOT & SPEED BUMPS	1998	17,156	624	27.5	624		4,498	41
42	WALLCOVERING/WINDOW TRMTS/TILES	1998	18,635	678	27.5	678		4,887	42
43	REMODELING - RESIDENT ROOMS	1998	37,050	1,347	27.5	1,347		9,484	43
44	WINDOW TREATMENTS/REMODEL RMS	1999	18,066	657	27.5	657		4,572	44
45	FIRE ALARM & HVAC/CEILING/HALLS/CALL LIGHTS	1999	25,000	909	27.5	909		6,250	45
46	REPAIR & REMODEL HALLWAY/DOOR MONITOR SYS	1999	23,425	852	27.5	852		5,786	46
47	REMODEL ROOMS/DOOR MONITOR SYS	1999	45,989	1,672	27.5	1,672		11,217	47
48	REMODEL RMS/LANDSCAPING	1999	53,572	1,948	27.5	1,948		12,906	48
49	WALLCOVERING/WINDOW TRMTS/TILES	1999	6,950	253	27.5	253		1,655	49
50	REMODELING RMS	1999	16,205	589	27.5	589		3,804	50
51	WALLCOVERING/FLOOR TILES/HANDRAILS	1999	28,464	1,035	27.5	1,035		6,598	51
52	REMODELING RMS	1999	47,115	1,713	27.5	1,713		10,778	52
53	NURSE STATION/ELEVATOR DOOR	1999	18,030	656	27.5	656		4,073	53
54	REMODELING ROOMS/WINDOW TRMTS	1999	170,712	6,207	27.5	6,207		37,501	54
55	FIRE DAMPERS	2000	4,950	180	27.5	180		1,073	55
56	REMODELING - WASHROOMS/MEDICAL & REC. RM	2000	35,550	1,293	27.5	1,293		7,488	56
57	FENCES	2000	3,557	129	27.5	129		737	57
58	WALLCOVERING/WINDOW TRMT - RES & DINING RMS	2000	69,939	2,543	27.5	2,543		14,093	58
59	FIREWALL/RESIDENT ROOM CEILINGS/TUCKPOINTING	2000	85,160	3,096	27.5	3,096		17,158	59
60	MAGNETIC DOOR/STEAMER	2000	16,334	451	27.5	451		2,577	60
61	HANDRAILS	2000	8,101	295	27.5	295		1,610	61
62	REMODELING - NURSE STATION/CORRIDOR/DINING RM	2000	126,731	4,608	27.5	4,608		25,153	62
63	PTAC UNITS	2000	3,550	129	27.5	129		704	63
64	CONCRETE PAVING	2000	11,700	425	27.5	425		2,320	64
65	IRRIGATION SYSTEM & ROOM PLATES	2000	10,425	379	27.5	379		2,037	65
66	DESIGN & BUILD ENABLING GARDEN	2000	19,832	1,323	15	1,323		7,275	66
67	CARPETING/WINDOW TREATMENT	2000	14,549	529	27.5	529		2,799	67
68	PTAC UNITS	2000	3,550	129	27.5	129		683	68
69	REMODELING - BREAK ROOM, MEDICATION RM	2000	39,886	1,450	27.5	1,450		7,673	69
70	TOTAL (lines 4 thru 69)		$ 5,992,934	$ 181,493		$ 195,918	$ 14,425	$ 3,058,745	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,992,934	$ 181,493		$ 195,918	$ 14,425	$ 3,058,745	1
2	SIDEWALK	2000	2,240	81	27.5	81		422	2
3	REMODELING - RESIDENT RMS, LOBBY, MAILROOM	2000	60,826	2,212	27.5	2,212		11,521	3
4	PTAC UNITS	2000	4,644	169	27.5	169		880	4
5	WOOD BLINDS FOR OFFICES	2001	3,538	129	27.5	129		639	5
6	CUBICLES	2001	8,332	303	27.5	303		1,502	6
7	REMODEL - ALL 2ND FLOOR RESIDENT ROOMS	2001	370,353	13,466	27.5	13,466		66,771	7
8	VERTICAL BLINDS FOR 2ND FLOOR ROOMS	2001	3,847	140	27.5	140		694	8
9	CARPETING FIRST FLOOR OFFICES/PLUMBING	2001	8,850	322	27.5	322		1,543	9
10	DROP & CHANGE SPRINKLER HEADS IN CORRIDOR	2001	5,097	185	27.5	185		871	10
11	REPAIR CEILING ON FIRST FLOOR	2001	25,000	909	27.5	909		4,280	11
12	REPAIR CORRIDOR IN LAUNDRY AREA	2001	10,000	364	27.5	364		1,653	12
13	TEN TON COMPRESSOR FOR KITCHEN UNIT	2001	4,441	161	27.5	161		691	13
14	INSTALL TILE FLOORING IN SERVICE HALLWAY	2002	11,300	411	27.5	411		1,627	14
15	INSTALL ELECTRICAL OUTLETS IN RMS 101 TO 110	2002	8,000	291	27.5	291		1,031	15
16	INSTALL PIPE RUN FR. ELECTRICAL CLOSET TO RM 104	2002	1,186	43	27.5	43		152	16
17	FRIEDRICH 11700 BTU PTAC UNITS - 2	2002	1,337	49	27.5	49		173	17
18	AMANA - PTAC 12000 BTU HEAT & 11700 PTAC UNIT	2002	1,379	50	27.5	50		173	18
19	REPLACE FIRE PANEL	2003	4,500	164	27.5	164		431	19
20	2 CANVAS AWNINGS	2003	1,650	110	15	110		234	20
21	RESTRIP AND ASPHALT SEAL PARKING LOT	2003	6,535	436	15	436		926	21
22	INSTALLATION OF 4 BATHRM WATER SHUT OFF VALVES	2004	2,360	86	27.5	86		168	22
23	WIRING AND INSTALLATION OF TV'S IN RES. ROOMS	2004	20,700	753	27.5	753		1,224	23
24	CONCRETE WORK DONE TO B WIND SIDE WALK	2004	5,540	201	27.5	201		310	24
25	REPAIR/REPLACEMENT OF ELECTRICAL LIGHTING COM	2004	7,350	267	27.5	267		412	25
26	INSTALL 80 SOLID CORE, FIRE RATED DOORS	2004	75,115	2,731	27.5	2,731		3,528	26
27	INSTALL NEW ELECTRICAL WIRING & PIPING - 1ST FLR	2004	33,552	1,220	27.5	1,220		1,271	27
28	INSTALLATION OF 20 AMP CIRCUIT IN STORAGE CLOSET	2005	822	26	27.5	26		26	28
29	REMOVED OLD & INSTALLED NEW WATER RECOND. SYS	2005	8,360	241	27.5	241		24	29
30	FIRE SPRINKLER SYSTEM	2005	2,060	28	27.5	28		28	30
31	MORTAR WORK & FIRE CAULK - 1ST FLOOR A,B,C WING								31
32	2ND FLOOR A,B,C WING, STORAGE RM & DINING RM	2005	9,740	133	27.5	133		133	32
33			ADJ TO SL	14,425			(14,425)		33
34	TOTAL (lines 1 thru 33)		$ 6,701,588	$ 221,599		$ 221,599	$	$ 3,162,083	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 672,462	$ 48,293	$ 68,981	$ 20,688	3-10 YRS	$ 376,993	71
72	Current Year Purchases	31,681	6,296	1,724	(4,572)	3-10 YRS	1,724	72
73	Fully Depreciated Assets	9,398						73
74	RELATED PARTY	5,243	458	458		3-10 YRS	2,660	74
75	TOTALS	$ 718,784	$ 55,047	$ 71,163	$ 16,116		$ 381,377	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,681,092	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 276,646	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 292,762	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,116	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,543,460	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	RENOVATE ALL SHWR RMS	$ 62,967	92
93			93
94			94
95		$ 62,967	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 32,555 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANGO	$ 295.13	$ 3,542	17
18					18
19					19
20					20
21	TOTAL		$ 295.13	$ 3,542	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number DEERBROOK CARE CENTRE STATE OF ILLINOIS # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 245,511	$		$ 245,511	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			136,719			136,719	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			314,970			314,970	4
5	Physician Care	39-3	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				238,367		238,367	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, I.V. THERAPY Other (specify): RENTALS	39-2					46,288		46,288	13
14	TOTAL			$		$ 697,200	$ 284,655		$ 981,855	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,185,873	$ 1,498,938	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 64,642)	1,449,608	1,449,608	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,401	188,655	6
7	Other Prepaid Expenses	30,774	30,774	7
8	Accounts Receivable (owners or related parties)	4,820	32,820	8
9	Other(specify): ESCROWS		712,026	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,730,476	$ 3,912,821	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	846,755	846,755	11
12	Long-Term Investments	1,955	1,955	12
13	Land		247,500	13
14	Buildings, at Historical Cost		1,849,704	14
15	Leasehold Improvements, at Historical Cost		4,684,941	15
16	Equipment, at Historical Cost	706,091	808,765	16
17	Accumulated Depreciation (book methods)	(633,154)	(3,723,649)	17
18	Deferred Charges		41,388	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTR. IN PROGRESS		62,967	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 921,647	$ 4,820,326	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,652,123	$ 8,733,147	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 422,079	$ 422,079	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	277,229	277,229	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,194	107,194	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,697	18,697	31
32	Accrued Real Estate Taxes(Sch.IX-B)		92,424	32
33	Accrued Interest Payable		21,073	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	40,661	40,661	36
37	DUE TO LESSOR/PRIOR OWNER	622,746		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,488,606	$ 979,357	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		310,194	39
40	Mortgage Payable		4,682,978	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,993,172	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,488,606	$ 5,972,529	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,163,517	$ 2,760,618	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,652,123	$ 8,733,147	48

***(See instructions.)**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,660,312	1
2	Restatements (describe):		2
3			3
4	ROUNDING ADJ.	5	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,660,317	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	253,200	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(750,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (496,800)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,163,517	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,860,521	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,860,521	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	82,080	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 82,080	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,942,601	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,168,635	31
32	Health Care	3,286,957	32
33	General Administration	3,138,981	33
	B. Capital Expense		
34	Ownership	984,296	34
	C. Ancillary Expense		
35	Special Cost Centers	981,855	35
36	Provider Participation Fee	117,165	36
	D. Other Expenses (specify):		
37	NET VENDING COSTS	11,512	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,689,401	40
41	**Income before Income Taxes (line 30 minus line 40)****	253,200	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 253,200	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,897	2,417	$ 97,383	$ 40.29	1
2	Assistant Director of Nursing	1,710	1,965	58,163	29.60	2
3	Registered Nurses	27,330	29,636	872,408	29.44	3
4	Licensed Practical Nurses	26,911	28,455	621,231	21.83	4
5	CNAs & Orderlies	91,979	47,566	1,013,881	21.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,592	5,056	105,540	20.87	9
10	Activity Assistants	10,372	11,196	82,146	7.34	10
11	Social Service Workers	1,792	2,008	37,908	18.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	10,462	11,380	167,045	14.68	14
15	Cook Helpers/Assistants	15,242	16,137	115,014	7.13	15
16	Dishwashers					16
17	Maintenance Workers	6,358	7,031	93,069	13.24	17
18	Housekeepers	16,743	18,113	154,741	8.54	18
19	Laundry	10,657	11,230	75,817	6.75	19
20	Administrator	2,109	2,753	147,781	53.68	20
21	Assistant Administrator	1,860	2,126	56,364	26.51	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,038	20,232	349,398	17.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,963	2,111	32,251	15.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	250,015	219,412	$ 4,080,140 *	$ 18.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	189	$ 13,054	1-3	35
36	Medical Director	96	9,600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	1,255	125,206	10-3	38
39	Pharmacist Consultant	176	3,850	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47	PSYCHOLOGIST	74	5,679	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,790	$ 157,389		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY DUMONT	ADMIN		$ 99,604
JUDY JUNE	ADMIN		48,177
KATHY SMITH	ASST. ADMIN.		56,364
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 204,145

B. Administrative - Other

Description	Amount
WITTINGHAM MANAGEMENT ASSOC. LLC	$ 586,448
CHESTERFIELD LLC	195,483
TOTAL (agree to Schedule V, line 17, col. 3)	$ 781,931
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		402,784
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 402,784

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 110,700
Unemployment Compensation Insurance		55,894
FICA Taxes		306,709
Employee Health Insurance		235,568
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		12,234
EMPLOYEE PHYSICAL EXAMS		3,510
PENSION/PROFIT SHARING PLANS		9,489
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 734,104

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,365
Health Care Worker Background Check	752
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	177,373
TRUST/FRANCHISE/CONTRIB/ETC	5,805
LICENSES & PERMITS	3,313
DUES & SUBSCRIPTIONS	11,375
MGMT CO ALLOCATION	1,600
TRUST/FRANCHISE/CONTRIB/ETC	(5,805)
Less: Public Relations Expense	(120,241)
Non-allowable advertising	(49,805)
Yellow page advertising	(7,327)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,405

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	288
RELATED PARTY	10,954
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,242

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	06/2004	$ 1,765	3	$	$	$ 294	$ 588	$ 588	$ 295	$	$	$
2	PAINT/DECORATING	06/2005	3,753	3				626	1,251	1,251	625		
3													
4													
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18													
19													
20	TOTALS		$ 5,518		$	$	$ 294	$ 1,214	$ 1,839	$ 1,546	$ 625	$	$

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE - $12187**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,266** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **117,165**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees